

The State Health Plan
PREVENTION PARTNERS
WORKSITE SCREENINGS

Subscribers of the State Health Plan, BlueChoice, Cigna, and MUSC Options will have the opportunity to receive a thorough preventive health screening on **Thursday, October 11, 2007 at the Catawba Regional Center, located at 215 Hampton Street in Rock Hill, S.C.** This screening will be available for just a \$15 co-payment. Your insurance pays the rest! Within two weeks of your screening, you will receive your personal health profile, highlighting any values outside the normal range. You can even send this report to your physician or take a copy with you on your next doctor's office visit, which may save you money and keep you from duplicating tests.

Worksite Screening Components

Health risk appraisal:

This screening includes a complete wellness profile

Lipid profile, including:

- Total cholesterol.
- Low density lipoproteins (LDL). LDL is a risk factor for heart disease. It can clog arteries and prevent oxygen-rich blood from flowing to your heart.
- High density lipoproteins (HDL). HDL helps move the LDL (the "bad" cholesterol) away from your arteries and prevents buildup of fats on arterial walls.
- Triglycerides. A contributor to the hardening of the arteries and ultimately, heart disease. Elevated triglyceride values can also be an indicator of diabetes.

Chemistry profile including:

- Blood Urea Nitrogen (BUN) and creatinine. These tests help measure and assess kidney function.
- Glucose. This test measures blood sugar level. New diabetes guidelines have lowered the level of glucose that defines the disease to 126 mg./dl.
- Electrolytes. This test measures Sodium, Potassium, Chloride and Bicarbonate. These four elements control the body's pH (acid/base) balance.

Hemogram, including:

- Red and white blood cell count
- Hemoglobin
- Hematocrit

Also includes Blood Pressure, Height and Weight

Registration

To register for this screening, you need to complete the registration form below and return it to Prevention Partners, 1201 Main Street, Suite 300, Columbia, SC 29201 **along with a check for \$15 made payable to Carolina Occupational Health Screening Group (or COHSG).**

We will notify you of your appointment time 1-2 weeks prior to the screening. If you have any questions, please email emcelveen@eip.sc.gov.



REGISTRATION FORM: Rock Hill, S.C. – October 11, 2007

(Registration deadline: September 30, 2007 – registrations postmarked after this date will be returned)

Terms and Conditions

- There is a 12-hour fast prior to your screening (you may have water and any required medications you may be taking)
- Participants are required to complete all components of this health screening. This includes height, weight, blood pressure, blood draw, and paperwork.
- Your insurance card ID number will be required the day of the screening for claim filing
- Insurance allows for **ONE** Prevention Partners screening per calendar year (January-December)
- **Spouses are not eligible** (only spouses who are state employees carrying their own insurance or who are retired state employees carrying their own insurance would be eligible)
- **Dependents are not eligible**
- **If Medicare or Tri-care is your primary insurance, you are not eligible**
- **NOTE:** Due to the size and nature of this screening, it is not possible to honor every request we receive asking for an early appointment time. **Appointment times are assigned on a first come first serve basis.** Once we receive your check and registration form, we will notify you of the earliest appointment time available. By registering for this screening, you acknowledge that you understand that your appointment time can range anywhere between 8 AM and NOON. If an appointment time anywhere in this time frame is not acceptable due to a medical condition, work schedule, etc., it may be in your best interest to be screened through your personal physician.

Name: _____ Work Phone: _____ Home/Cell Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Email (required in order to receive a confirmation/reminder): _____

Please check the box that represents your insurance coverage:

- | | |
|--|---|
| <input type="checkbox"/> My primary insurance is State Health Plan | <input type="checkbox"/> My primary insurance is BlueChoice |
| <input type="checkbox"/> My primary insurance is Cigna | <input type="checkbox"/> My primary insurance is MUSC Options |

I hereby certify that I am an employee or retiree with insurance coverage through the state of South Carolina and that I have read the terms and conditions listed above. I affirm that the information I've given is true and correct. Any discrepancy may result in further billing by the provider.

SIGNATURE _____ Insurance Card I.D. Number (not your SSN#): _____